STATE OF CONNECTICUT
State Innovation Model
Equity and Access Council

Meeting Summary
May 07, 2015
6:00-8:00p.m.

Location: Connecticut Behavioral Health Partnership, Hartford Room (Suite 3D), 500 Enterprise Drive, Rocky Hill, CT

Members Present: Ellen Andrews, Linda Barry, Johanna Bell, Peter Bowers, Arnold DoRosario; Bonita Grubbs; Margaret Hynes; Gaye Hyre; Robert Russo; Donald Stangler; Victoria Veltri; Keith vom Eigen; Robert Willig; Katherine Yacavone

Members Absent: Maritza Bond; Christopher Borgstrom; Kristen Hatcher; Roy Lee; Kate McEvoy

Other Participants: Adam Stolz, Patricia Checko for Alice Ferguson; Mark Schaefer

The meeting was called to order at 6:05pm.

1. Introductions
Council members introduced themselves.

2. Public Comment
Sheldon Toubman gave public comment via correspondence prior to the meeting.

3. Minutes
Gaye Hyre motioned to approve the April 23rd meeting minutes. Katherine Yacavone seconded the motion and the minutes were approved. Bonita Grubbs abstained.

4. Review Process and Timeline for Issuing Phase I Report
Adam Stolz of The Chartis Group reviewed the EAC's timeline, modified to reflect the additional meeting.

Victoria Veltri suggested a copy of the EAC recommendations be made available to the Healthcare Innovation Steering Committee (HISC) members before they are reviewed in session. Ellen Andrews suggested a pre-meeting question and answer session be held with an invitation to other Council's members, citing MAPOC.

Ms. Andrews also suggested the PMO host a public comment period. The Council discussed sending the recommendations to the Steering Committee before or after posting it for public comment. Mark Schaefer stressed the importance of vetting the comment and revision process with the HISC. The process for reviewing SIM Council recommendations and reports is on the HISC's agenda for its May 14 meeting. The HISC will not review the EAC recommendations during its May 14 meeting. Gaye Hyre requested that sufficient time be given for the public comment session. Additionally, she requested the public comment period be widely publicized to maximize participation by the public. Ms. Andrews

suggested an online format in which participants could see what other comments were made.

The Council discussed the process surrounding recommendations that were discussed but did not gain the Council's approval by consensus. Mr. Stolz proposed that items obtaining broad support without consensus be included in the report. The report would note the lack of consensus on the recommendation. Donald Stangler asked that consensus be defined in the report. By request, Mr. Stolz confirmed that stating consensus implied that the group supports adoption of a position, even if some individual members did not personally endorse the position. Linda Barry suggested the report include a section detailing the arguments in favor and against each non-consensus item. Kathy Yacavone added that this section would enrich a public comment session, should the Council have one. Ms. Veltri commented that it would aid the HISC in its review of the recommendations.

5. Review and Act on Slate of Recommendations (Continued from 4/23)

Mr. Stolz reviewed the remaining recommendations not discussed during the April 23 EAC meeting.

5.4 Provider Communications: "Providers should be informed about the nature of shared savings contracts, their objectives, and the financial incentives that they contain for providers and/or organizations that deliver care. This should include, but not be limited to, information about incentives to lower the total cost of care and definitions of under-service and patient selection. This latter information should be communicated in a consistent manner to all providers."

Mr. Stolz reviewed recommendation number 5.4, "Provider Communication." Additionally, Mr. Stolz reviewed the suggested revisions submitted by the State Innovation Model's (SIM) Project Management Office (PMO) for consideration at the EAC's meeting on April 23rd. The Council discussed transparency, supporting provider notification that they are being monitored, but not divulging how. The Council decided by consensus to adopt the recommendation with the suggested changes with the exception of the last clause reading "…which will have a deterrent effect." The Council felt that clause was superfluous.

5.2 Consumer Communications: Accessibility and Consistency: "The type of information described in Recommendation #1 should be communicated to all consumers via a set of consistent messages. Messages should be written and distributed in a manner that is accessible and comprehensible by all consumers. Information should be made available both in advance of receiving care (i.e. at the time of insurance enrollment) and at the point of care (i.e. in the provider office). While these messages should be tailored as appropriate to provide information relevant to specific groups (e.g. enrollees in different insurance products, people with different clinical conditions), the core elements should be consistent in order to promote shared understanding across populations, promote continuity of information as consumers' insurance or health status changes, and give providers standard guidance about engaging consumers that aligns with what consumers are being told."

Mr. Stolz reviewed recommendation number 5.2, "Consumer Communications: Accessibility and Consistency." Ms. Veltri reminded the Council that consumer communications would be crafted by a work group as outlined in recommendation 5.3, "Consumer Communications: Content Development," approved by the Council at the April 23rd meeting.

Peter Bowers questioned the mechanics of patient communication when they are retrospectively attributed. Additionally, Dr. Bowers expressed support for the recommendation conceptually, but questioned its feasibility in practice give the mechanics of onboarding new patients. Arnold DoRosario said the consumer should be at liberty to change their provider at any time. The Council discussed who should deliver the communication. Ms. Andrews suggested the ACO deliver the communication given the Council's concern about underservice by providers. Keith vom Eigen remarked on the complicated nature of shared savings messaging. Dr. Barry suggested a vehicle for patients to ask questions. Dr. Barry and Dr. vom Eigen stressed the importance of simplified, clear, and easy to understand language in the communication for consumers. Ms. Yacavone suggested the recommendation be tailored to different populations. Gaye Hyre stressed the importance of a patient question and answer outlet. Mr. Stolz asked if Council members had any specific edits to the language to propose. Ms. Veltri suggested the "i.e.s" in the recommendation be changed to "e.g.s." The Council agreed by consensus to adopt the recommendation.

4.9 Peer Reporting: "The State should establish whistle-blower protections for employees or contractors of the ACO who report evidence of under-service, or of undue pressure from the ACO to under-serve."

Mr. Stolz reviewed recommendation 4.9, "Peer Reporting," which was submitted by the SIM PMO office prior to the last EAC meeting on April 23rd but has not previously been considered by the Council. Ms. Yacavone asked if there were whistleblower laws already in existence that this recommendation would fall under. Mr. Stolz suggested the recommendation be edited to suggest the state should establish an additional provision if sufficient ones do not exist. Bob Willig said some companies have these provisions already in place. Dr. DoRosario said a Medicaid inquiry can be triggered through whistleblower policies. Mark Schaefer commented that the regulations relate to fraud and abuse. Ms. Andrews commented that while under-service is immoral, it is not illegal. Dr. Barry commented on the distinction between public and private organizations with respect to regulations. The Council adopted the recommendation by consensus with the change proposed by Mr. Stolz.

4.8 Accountability: Public Reporting: "Entities involved in the use of shared savings contracts in Connecticut should report information in order to inform the public and allow for the effect of these contracts to be evaluated using an array of relevant data points. At a minimum, this should include:

A) Payers should publicly report on an annual basis: the names of the ACOs with which it has shared savings contracts, the number of lives attributed to each, a description of methods that it used during the prior year to monitor for under-service and patient selection, and a summary of the results of that monitoring which includes a statement describing any instances in which shared savings were withheld from an ACO.

B) OHA should publicly report on an annual basis a summary of the activities it undertook related to under-service and patient selection including: patient complaints received by the nurse consultant, cases referred to payers, ACOs, provider groups, and/or licensing authorities for further evaluation, and actions taken to initiate corrective actions."

Mr. Stolz reviewed recommendation 4.8, "Peer Reporting," and the suggested revisions submitted by the SIM PMO office and by Mr. Stolz and Katie Sklarsky of The Chartis Group

for review at the last EAC meeting on April 23rd. Dr. DoRosario commented that the goal is to provide quality care and meet the criteria of patient satisfaction. Dr. vom Eigen commented that some ACO and insurer contract information is propriety. Ms. Andrews stressed the importance of public reporting and suggested another committee be formed to address it. Bonita Grubbs asked who the public is and how the reporting would take place. The Council discussed the differences between public and private reporting and the existence of these provisions in contracts. Ms. Yacavone agreed that the term "public" needs definition in the recommendation and asked if there are different levels of transparency requirements already imposed by CMS. Additionally, she asked if there is mandatory reporting required by the federal government in regards to SIM funds. It was clarified that this recommendation does not concern reporting required by the SIM grant. The Council agreed by consensus to adopt the recommendation with revisions.

4.1 ACO Internal Monitoring: "ACOs should establish performance standards, monitor for inappropriate practices including under-service and patient selection, and hold member groups and providers accountable. As a condition of participating in shared savings contracts, payers should require ACOs to establish governance and performance management processes that meet minimum criteria, including promotion of evidence-based medicine and patient engagement, reduction in variations in care, and monitoring for under-service and patient selection."

Mr. Stolz reviewed recommendation number 4.1, "ACO Internal Monitoring," and the suggested revisions submitted by the SIM PMO office for review at the last EAC meeting on April 23rd. Dr. DoRosario remarked that in the shared savings process, it is more costly to deny service to a patient who will ultimately find care in the Emergency Department. The Council discussed an appeal process. Dr. vom Eigen illustrated the need for an appeal process with a common scenario where the provider prescribes antibiotics conservatively and the patient disagrees with that course of treatment and files a complaint. Ms. Veltri explained that The Office of the Healthcare Advocate receives these types of calls but the patient usually decides against filing a complaint after discussing the grievance with a nurse consultant. Ms. Andrews suggested monitoring and investigation be conducted by an outside organization. Ms. Veltri endorsed the independence as it allows patient consultation from a professional who is not invested in the process. She said the ACO may be the right place to go. Ms. Andrews disagreed. The Council agreed to revert the recommendation to the original form and adopt the recommendation by consensus, without any changes related to the PMO's comment.

4.4 Concurrent Monitoring: Nurse Consultant: "A nurse consultant (i.e. ombudsman) will play a key role as a "hub" of information related to under-service and patient selection and act as a one-stop source of information for consumers. The nurse consultant should be dedicated to addressing underservice and patient selection concerns arising from shared savings and related value-based contracting programs. This role will be funded by the SIM initiative and be overseen by the Office of the Healthcare Advocate (OHA)."

Mr. Stolz reviewed recommendation number 4.4, "Concurrent Monitoring: Nurse Consultant." Ms. Veltri discussed the original charge of the OHA nurse consultant role. Ms. Andrews suggested the term "hub" be changed to "source." Dr. Barry asked how the complaint process currently operates. Ms. Veltri explained that OHA receives the complaint and begins its investigation with the provider to determine if the service was or was not medically necessary. The nurse consultant reviews the contract terms and medical records

and determines whether the complaint is legitimate. Dr. Bowers asked how OHA interfaces with the section of the Department of Public Health (DPH) that handles complaints about providers. Ms. Veltri explained that when the complaint involves quality of care the nurse consultant conducts an initial investigation and refers at his/her discretion to DPH. Dr. Barry suggested the nurse consultant outline the next steps for the consumer. Mr. Stolz said if the issue is underservice the complaint might be referred to or from the payer, which is what the term "hub" referred to – information may flow in multiple directions. Ms. Hyre suggested "in a timely fashion," be added to the recommendation's language. The Council discussed barriers to submission of written complaints by consumers. Dr. Barry suggested the language "referred to appropriate body," be added to the recommendation. The Council suggested language be added to outline a clear path to complaint resolution. Dr. vom Eigen asked if OHA had legal authority to which Ms. Veltri replied that they have regulatory authority and legal authority if needed. The Council adopted the recommendation by consensus provided that changes are made responsive to the group's discussion.

4.5 Concurrent Monitoring: "Mystery Shopping: Mystery shopping programs should be implemented by all payers to detect potential patient selection activity amongst ACO participants. These programs should include core elements of the one that CHNCT administers today on behalf of DSS, with modifications appropriate to each payer population."

Mr. Stolz reviewed recommendation number 4.5, "Concurrent Monitoring: Mystery Shopping." Dr. DoRosario commented that mystery shopping is a complicated, expensive endeavor and asked to what end? Dr. Dorosario added that Northeast Medical Group conducts mystery shopping internally to improve administrative processes but does not take away points based on performance. Ms. Andrews commented that mystery shopping is an important safeguard against cherry-picking patients during appointment scheduling. Dr. vom Eigen agreed that patient cherry-picking occurs as the provider level. Dr. DoRosario said that the shared savings program innately safeguards against this behavior. For example, if a patient is blocked from an appointment, they will end up in the emergency room, a more expensive endeavor than the initial appointment. Dr. vom Eigen said that some providers may differ in opinion. He added that mystery shopping is a good way to measure access to care.

Dr. Barry observed that there are multiple activities mystery shopping may measure. Ms. Andrews said that mystery shopping is a good way to test against patient selection that might go unnoticed in a sea of data. After some discussion regarding the applicability of mystery shopping, Dr. vom Eigen suggested it be one of the tools used in monitoring, but not necessarily used by every payer. Ms. Andrews added that mystery shopping should be implemented among of number of other monitoring mechanisms. Dr. Bowers commented that mystery shopping may not detect the type of patient selection or under-service in question; it may occur during later points of care. Dr. Willig agreed that the EAC should monitor if practices are conducting patient selection based on disease but questioned whether scheduling personnel would have the knowledge to screen and deny patients access. He asked for clarification regarding the mystery shopping inquiries and stressed the importance of phrasing to figure out the risk and reward of a program like this. Ms. Yacavone suggested a follow up patient survey to address care based on disease type and whether the patient was able to access the appropriate specialist. Ms. Hyre pointed out that if she is denied an appointment after disclosing a history of cancer that is adverse selection, to which Dr. DoRosario agreed. The Council agreed by consensus to adopt the

recommendation, provided that it not call on each payer to implement a mystery shopper program.

4.6 Accountability: Corrective Action: "When a payer, via monitoring and follow up investigation, determines that an ACO or its member provider(s) have engaged in repeated or systematic under-service and/or patient selection, it should provide the ACO with a written finding of relevant facts. The ACO should have an opportunity to appeal any such finding. If the finding is verified, the payer should place the ACO on a corrective action plan (CAP) for a period of time during which the ACO will not be eligible for receiving shared savings. If after the CAP period is complete, performance concerns are not addressed, the ACO may face termination from the shared savings program. The same process should apply if ACOs do not abide by required rules for participation in a shared savings program. Initially when an ACO is placed on a CAP support should be provided through collaborative learning with well performing ACOs or other means that will help the ACO to identify and address areas of concern."

Mr. Stolz reviewed recommendation number 4.6, "Accountability: Corrective Action." Dr. DoRosario supported the recommendation and commented that it is due process. Dr. Bowers commented that these instances would be rare. The Council reviewed the suggested revisions submitted by Kate McEvoy and the SIM PMO office for review at the last EAC meeting on April 23rd. The Council agreed to keep the recommendation language as is and the recommendation was approved by consensus.

4.7 Retrospective Monitoring: Long-Term Analysis: "After Connecticut gains more experience with shared savings contracting, an independent third party (non-payer, non-provider) should conduct a retrospective, multi-payer analysis of how value-based contracting is impacting service delivery. This analysis may rely on the all-payer claims database (APCD) and/or other sources of data. This analysis should be overseen by a committee of clinical and analytic experts who will use available data (i.e. claims data, patient feedback, clinical data) to evaluate the impact of shared savings contracts on healthcare delivery practices and outcomes. This will include patterns of under-service and patient selection. The analysis will seek to understand root causes and recommend adjustments to contracting methods and supplemental safeguards going forward. The goal of this more comprehensive analysis will be to identify and address any programmatic elements or unwanted ACO/provider behaviors not captured by initial recommended monitoring that are contributing to equity and access problems, in particular under-service and patient selection."

Mr. Stolz reviewed recommendation number 4.7, "Retrospective Monitoring: Long-Term Analysis" and the suggested revisions submitted by the PMO for the last EAC meeting on April 23rd. The Council agreed to the suggested revisions and approved the recommendation by consensus.

3.5 Reinvestment of Non-Retained Savings: "When an ACO demonstrates cost savings, but is not eligible to receive the savings (either because the MSR was not met or because quality/performance targets were not met), the funds should be reinvested either (a) into the community's delivery system as a whole or (b) into the ACO (subject to a set of guidelines to ensure that funds are earmarked to support the ACO's future ability to deliver high performance, and are not used to finance incremental growth or compensation)."

The Council agreed to continue the discussion past the initial meeting end time. Mr. Stolz reviewed recommendation number 3.5, "Reinvestment of Non-Retained Savings." Dr. Willig noted a lack of employer support for the recommendation. Dr. Bowers agreed. Mr. Stolz reminded the Council that this is a narrowed version of the original recommendation. Dr. Bowers agreed that the revision represents a substantial change from the original. Dr. vom Eigen suggested the patient (employee), rather than the ACO, should keep the non-retained savings given that they carry the burden of cost and of the effects of the under-service. Ms. Hyre said this recommendation could encourage continued poor service. Dr. Stangler remarked that payers are encouraging providers to succeed. Ms. Andrews said that the recommendation is not targeted for the present, but rather to guide future instances. Currently, the quality thresholds are low to attract provider participation. Ms. Andrews said the recommendations provide an opportunity to put safeguards in place before problems occur. Robert Russo added that if you do not control the pre-authorization process, where is the incentive to change the system?

Dr. DoRosario commented that there will be no shared savings without provider compliance. Ms. Yacavone commented that up front investment needs to be made to the system and this recommendation provides a source of funding for that. Ms. Veltri said reinvesting savings in helping providers who did not make their goals incentivizes providers to not make their goals. In this case, there is nothing to incentivize the ACO to improve. Dr. vom Eigen noted that some providers won't have the initial money to invest in improvement. Ms. Hyre said a third entity could administer the reinvestment funds in order to prevent an ACO from misusing them. Dr. Willig asked if a physician group did not hit any targets, would the money be given back to them? Ms. Andrews said the money would go to an outside entity who would administer a corrective action plan. Dr. DoRosario asked how a provider could make their quality measure thresholds by cutting corners on care. Ms. Veltri noted that there are five star hospitals that still have poor patient safety measures. Mr. Stolz recapped the points for and against this recommendation.

Mr. Stolz recommended the Council include an account of the discussion in the report's narrative, and indicate that it did not reach consensus. The Council agreed. Ms. Andrews suggested the possibility of writing a minority report.

Ms. Grubbs motioned to adjourn. The motion was seconded by Ms. Yacavone and the meeting was adjourned.

4. **Discuss Framework for Proposing Implementation Methods**
5. **Additional Comments on Narrative in Version 1.1 of Draft Report**
6. **Closing Comments**

These agenda items were tabled due to time constraints.